APPLICATION FOR ADJUSTMENT OF CLAIM

State Form 29109 (R3 / 3-95)

STATE USE ONLY
Application number

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room 196
Indianapolis, Indiana 46204

INSTRUCTIONS: *Please TYPE or PRINT.*
File in TRIPLICATE.
BE SURE TO SIGN BACK.

Name of plaintiff / employee				Name of defendent / employer
Street address				Street address
City	State	ZIP code	**vs.**	City State ZIP code
Telephone number ( )	Social Security number			Telephone number ( )
Employer's Worker's Compensation Insurance Company *(if known)*				

The undersigned petitioner respectfully requests a hearing before a member of the Board for the following reasons. *(please check one)*

☐ Worker's Compensation Claim ☐ Occupational Disease Claim ☐ Change of Condition

Date of injury / last exposure / death	Date employer notified of illness / injury / death	Length of time partially or totally unable to work
Actual location of incident *(street, city and state)*		County of incident
Average weekly earnings of the employee at the time of illness / injury / death $		Amount claimed for medical expenses $

If employer was not notified within 30 days of the injury / illness / death, please state fully the reason for this omission.

Briefly describe how the accident / exposure occurred.

If an employee has died as a result of the injury / exposure, complete this section for all persons surviving as all and only dependents.

NAME	AGE	RELATIONSHIP	WHOLLY OR PARTIALLY DEPENDENT	ADDRESS

Comments or additional information that you feel is pertinent to this claim.

Name of attorney	
Address	
City, state, ZIP code	
Area Code	Telephone number
Attorney number	

Signature of petitioner

SIGN HERE

Date signed *(month, day, year)*

A COPY OF THIS APPLICATION MUST BE SERVED UPON THE OPPOSING PARTY AT THE TIME OF FILING